Posted by Vermont Department of Health
June 17, 2005

Clinical Elements of Statewide Care Management System
Meeting Notes
June 3, 2005

Attended by CRT directors, community stakeholders, and medical directors from hospitals and designated agencies (attendance list attached). Facilitated by Dr. Robert Pierattini.

Goal of the Meeting and Overall Mission of the Group
Keep primary focus on clinical definitions and levels of care.
Build on what is already working.
Develop common protocols for assessment, admission and exit.
Work toward leveled, unified policies across all facilities and programs.
New IT systems are a major element but beyond the scope of this group.

Legal Issues
DMH legal division reports that we are moving ahead based on current configuration.
Recognition that operating unlocked sub acute units is likely to require changes in how ONH and PPV work. PPV currently limited to 30-60 days. The PPV concept is good but implementation is clumsy.
Success of ONH is a function of degree to which client is actively involved.
ONH has systemic problems in any case.
Consider replacing ONH with advance directive or 'contract' model.
Existing legal mechanisms are 'clunky and unpleasant'.
However if legal mechanisms become too streamlined, the likelihood of breaching civil rights increases; the cumbersome feature inadvertently serves as a buffer.
There is a wide spectrum between voluntary and involuntary status with many gradations.
Legal issues will be a long conversation.
Recommendation to create legal issues workgroup.

Sub Acute Rehab Units
Sub acute is not one general group, it is composed of several distinct subgroups.
Can include both locked and unlocked units according to the population subcategory.
Estimated 16 to 20 refers to # of beds; the # of people served by them is greater than that.
Many in the group questioned whether 16 to 20 beds will be adequate.
All sub-acute requires rapid access to acute care.
Some patients at VSH have involuntary status but agree voluntarily to leave and collaborate on tx plan. This would be the case for many coming into sub acute.
Current Brooks Rehab patients at VSH parallels sub acute population.
Brooks rehab team reports that currently some patients staying two years.
Why just move Brooks Rehab away from the inpatient site?
Sub acute should replicate natural community environment as much as possible.
12 beds too large, becomes mini- institution. 4 beds too expensive to operate.

Reducing VSH census is one of the acknowledged goals.
Easy movement between acute and sub acute is essential.
For sub acute not to bottleneck, need to have the "go back to" place (currently VSH) as well as better developed step down options.
Create partial hospitalization resources as part of this mix.
CRT directors will take part in a workgroup for defining the environment and programming for sub acute facilities that will bring it's findings to the larger group.

Secure Residential Units
Clients are psychiatrically stable.
Involuntary legal status, voluntary clinical status (actively collaborating on plan of care.)
Facilities are alarmed, but not locked, staff secure, 1 on 1 ratio. Bracelets may be used.
'Secure' means 'close and careful supervision'.
Necessary to identify or create alternate facility if client violates legal directives.
Currently this is VSH – it's all we have at the moment. However acute care is not really an appropriate placement in this situation, because it's not a treatment need.

Vermont State Hospital
VSH serves a multitude of functions at present; acute care is only one of them.
Well-functioning VSH is an essential component until new inpatient units are established.

Finance
Success of new capacity depends on state commitment to sustained funding.
Models of treatment align behind whether or not CMS reimburses them.

Forensic Observation
Typically does not require an acute care setting.
Risk that some patients in the forensic observation population could inflict trauma on other patients and therefore should be on separate unit.
When done in a hospital, the need for forensic evaluation is coincidental to medical need.
We should always measure inpatient admission appropriateness based on clinical criteria.
In the real world, it's an intersection of legal, medical, political and psychiatric factors.
An elaborate system is now in place to steer this pop to Corrections whenever possible.
In the case of NGRI, person cannot go to Corrections, yet they are monitored by court.
CMS criteria for inpatient care are an important driving factor in hospital-based evals.
The group adopts as a philosophy: "people are treated in the appropriate level of care given the acuity of need, guided by LOCUS, regardless of legal status, to the extent possible."

Diversion Units
Who uses them? 1) those not needing inpatient care, but can't just turn away from them, 2) known to the system and VSH is not a good alternative, 3) unknown to the system.
Based on funding, ten new beds are proposed, regionally managed, statewide resource.
Descriptions of typical existing programs: parallel to voluntary inpatient care.
Voluntary and unlocked. Residential setting. 24/7 medical (nursing) staff.
It's not diversion for those needing involuntary treatment.

Screeners are usually the gatekeepers. LOS is 24 hours to a few months.
Client might go from ER assessment to diversion, but not directly to diversion.
Screening at ER must be substantial including past history information.
Admissions not limited to CRT. Few beds for public inebriate at this time.
Higher acuity is accepted if the client is known.
Some facilities combine step down and diversion.
But step down from diversion is not the norm.
Avoid having the operation of diversion beds cornered by CMS or accrediting entities.
Recommend locating new diversion beds close to inpatient care. Ability to communicate and coordinate with other facilities will be essential. Beyond that, won't be a highly defined and uniform model. Noted that HUD is a potential resource – HUD funded houses must take those with mental illness.
Recommend creating a workgroup on diversion capacity that will visit each existing site and report to large group.

Control
Care management system is about information access (helicopter report on traffic below.) In this way it is self-managing. There are traffic rules, but no centralized point of decision-making about the movement of individual clients.
Recommend creating an ongoing group to track and interpret the information on flow and make recommendations on self-correcting actions.

Other
Stay focused on what we are creating rather than what we are replacing.
Work on consistency and uniformity of standards of care.
DA's essentially propose to keep on doing what they are already doing, but serving higher acuity and greater numbers, as funding allows.
Vision for new facilities is to host/operate locally but use as a statewide resource.
Adapt existing care management system as much as possible, rather than starting anew.

Process Discussion
Keep the conversation going in all directions e.g. community stakeholders, Department of Health, providers, advisory committee, legislature and joint oversight committee. Others that it would be helpful to have here include state funding decision makers, community psychiatrists.
Bob will contact Paul Blake and ask him to communicate with the VSH Futures Committee about how the work of this group interfaces with the role of the Committee.
The group asked Bob Pierattini to facilitate in the future and he agreed.
The group will hold a conference call following the discussion between Paul Blake and Bob Pierattini to take about next steps. Date for next meeting TBA pending outcome of Bob P's discussion with Paul Blake.

Care Management System Meeting
June 3, 2005
List of Participants

Name	Agency/Organization
Patti Barlow	DMH
Frank Reed	DMH
Cathy Rousse	NKHS
Peter Thomashow	CVMH
John Stewart	RMHS
Graham Parker	HCRS
Nick Emlen	VCDMHS
Sandy Smith	CSAC
Jeff Rothenberg	CMC
Kevin Buchanan	CMC
Bill McMains	DMH
Bob Pierattini	FAHC/UVM
Fritz Engstom	Retreat Healthcare
Michael Sabourin	NKHS
Robert Jimerson	CSAC
Linda Corey	VPS
Beebe Potter	NCSS
Richard Lanza	LCMH
Ted Robbins	HCRS
Judith Hayward	HCRS
David McKay	RMH/RRMC
Stuart Graves	WCMH
Victor Martini	UCS
Michael Hartman	WCMH
Bea Grause	VAHHS
Richard Palmisano	Retreat Healthcare